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# Into the Future: The Statutory Implications of North Carolina's Telepsychiatry Program

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**Into the Future: The Statutory Implications of North Carolina’s  
Telepsychiatry Program\***

INTRODUCTION .....864

I. WHAT ARE TELEMEDICINE AND TELEPSYCHIATRY? .....866

    A. *The Definitions of Telemedicine and Telepsychiatry* .....866

    B. *The History of Telemedicine and Telepsychiatry* .....868

    C. *The Technology and Application of Telemedicine and  
    Telepsychiatry* .....869

    D. *The Benefits and Limitations of Telemedicine and  
    Telepsychiatry* .....871

II. NORTH CAROLINA’S FORAY INTO TELEMEDICINE .....872

    A. *Privately Funded Telemedicine Programs* .....872

    B. *North Carolina’s Statewide Telepsychiatry Program* .....874

III. THE STATUTORY IMPLICATIONS OF NORTH CAROLINA’S  
TELEPSYCHIATRY PROGRAM .....876

    A. *Informed Consent* .....877

        1. Problems with Applying North Carolina’s  
        Informed Consent Law to Telemedicine .....877

        2. States Requiring Informed Consent for  
        Telemedicine .....881

        3. Updating North Carolina’s Informed Consent  
        Laws .....883

    B. *Licensure* .....884

        1. Problems with Applying North Carolina’s  
        Licensure Laws to Telemedicine .....884

        2. Potential Legislative Solutions.....886

        3. Updating North Carolina’s Licensure Laws.....889

    C. *Reimbursement* .....891

        1. Problems with Reimbursement for Telemedicine  
        Services in North Carolina .....891

            a. *Federal, State, and Voluntary Reimbursement*.....891

            b. *Reimbursement in North Carolina* .....892

        2. States that Require Reimbursement for  
        Telemedicine .....894

        3. Updating North Carolina’s Telemedicine  
        Reimbursement Laws .....896

CONCLUSION .....898

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TABLE I: FIFTY STATES: TELEMEDICINE LAWS FOR INFORMED CONSENT .....	900
TABLE II: FIFTY STATES: TELEMEDICINE LAWS FOR LICENSURE.....	904
TABLE III: FIFTY STATES: TELEMEDICINE LAWS FOR LICENSURE FOR PRIVATE REIMBURSEMENT .....	908

### INTRODUCTION

Mr. Smith waits in the emergency department of a rural North Carolina hospital. He is schizophrenic, and the emergency department physicians determined that he is experiencing a psychotic episode. He needs to be seen by a psychiatrist immediately; unfortunately, the rural hospital does not have access to a full-time psychiatrist. So, Mr. Smith will wait—potentially for hours, or even for days—until the hospital’s part-time psychiatrist is able to see him.

This scene is one that could occur in fifty-eight of North Carolina’s one hundred counties due to a shortage of mental health providers.<sup>1</sup> Indeed, the majority of North Carolina emergency departments do not have access to a full-time psychiatrist.<sup>2</sup> Often, patients like Mr. Smith must “wait for hours—sometimes as long as days or weeks—for an appropriate psychiatric consultation after an initial [emergency department] determination of need.”<sup>3</sup> Unfortunately, Mr. Smith’s experience is far more common in North Carolina than it is nationally,<sup>4</sup> and there is a twenty-five percent chance that a patient like Mr. Smith will be readmitted to the emergency department within thirty days.<sup>5</sup>

In order to address the shortage of mental health providers and the long waiting periods for behavioral health patients in emergency departments, North Carolina implemented the North Carolina Telepsychiatry Program.<sup>6</sup> The purpose of the program is to “ensure

1. OFFICE OF THE GOVERNOR OF N.C., FACT SHEET: USING TECHNOLOGY TO TAKE ON NC’S TOUGHEST MENTAL HEALTH CHALLENGES (2013) [hereinafter USING TECHNOLOGY], available at <http://governor.nc.gov/sites/default/files/Telepsych%20Fact%20Sheet.pdf>.

2. *Id.*

3. *Id.*

4. *Id.* (“Between 2008 and 2010, 9.3% of visits to emergency departments at North Carolina hospitals were related to an acute psychiatric episode or a related illness or injury, compared to 5% nationally.”).

5. *Id.*

6. *Id.*; see also Press Release, N.C. Dep’t of Health & Human Servs., Governor McCrory Announces Statewide Telepsychiatry Plan to Improve Quality and Access to

that individuals experiencing an acute mental health or substance abuse crisis who present to an [emergency department], receive timely specialized psychiatric treatment in coordination with available and appropriate clinically relevant community resources.”<sup>7</sup> The program hopes to use technology “to connect people with appropriate treatment programs so patients can avoid long waits in the emergency room.”<sup>8</sup>

While the North Carolina Telepsychiatry Program is a solution to the lack of mental health providers in North Carolina, the current informed consent, licensure, and insurance reimbursement statutes do not readily apply in the telemedicine context. This Comment conducts a broad survey of other states’ laws that specifically apply to telemedicine and categorizes them based on content. This Comment then argues that North Carolina should adopt certain aspects of other states’ statutes in order to protect the patient and bring North Carolina to the forefront of the telemedicine movement. Specifically, North Carolina should (1) update its informed consent law by requiring informed consent for telemedicine and specifying the categories of information that should be included in the consent; (2) implement a telemedicine licensure system; and (3) implement private insurance reimbursement parity for telemedicine services.<sup>9</sup> This argument proceeds in four parts. Part I defines both telemedicine and telepsychiatry and gives a brief history of each. Part II discusses the telemedicine programs upon which the North Carolina Telepsychiatry Program is modeled and explains the details of North Carolina’s Telepsychiatry Program. Part III surveys and categorizes other states’ informed consent, licensure, and reimbursement laws as applied to telemedicine and argues that North Carolina should update its statutes by mirroring various aspects of other states’ statutory schemes. Finally, Part IV concludes this Comment by making overall recommendations.

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Mental Health Care (Aug. 16, 2013), *available at* [http://www.ncdhhs.gov/pressrel/2013/2013-08-16\\_Gov\\_McCrory\\_Announces\\_Mental\\_Health.htm](http://www.ncdhhs.gov/pressrel/2013/2013-08-16_Gov_McCrory_Announces_Mental_Health.htm) (noting that the program was announced by Governor Pat McCrory on August 16, 2013, and became effective in January 2014).

7. N.C. DEP’T OF HEALTH & HUMAN SERVS., STATEWIDE TELEPSYCHIATRY PROGRAM PLAN 4 (2013), *available at* <http://governor.nc.gov/sites/default/files/TelepsychiatryProgramPlan.pdf>.

8. USING TECHNOLOGY, *supra* note 1.

9. Although there are states that have implemented various aspects of this scheme, no one state has implemented all three reforms. *See infra* Tables I–III. Therefore, by implementing all three proposed reforms, North Carolina will become a national leader in telemedicine.

## I. WHAT ARE TELEMEDICINE AND TELEPSYCHIATRY?

A. *The Definitions of Telemedicine and Telepsychiatry*

In order to understand how the informed consent, licensure, and reimbursement statutes relate to telemedicine—and more specifically North Carolina’s Telepsychiatry Program (the “Program”)—the terms telemedicine, telehealth, and telepsychiatry must be defined and the underlying technology must be explained. For the purposes of this Comment, telemedicine is defined as “the use of advanced telecommunication technologies to exchange health information and provide healthcare services across geographic, time, social and cultural barriers.”<sup>10</sup> While there are other definitions of telemedicine,<sup>11</sup> this Comment adopts this definition because it provides a vivid image of the term.

One of the difficulties of defining the associated technological terms is the fact that states often use the words “telemedicine” and “telehealth” interchangeably. Both terms essentially have the same meaning<sup>12</sup> and can be better understood by using the analogy of a square and a rectangle. Telemedicine—the square—has a narrower definition because it is often used in the context of utilizing medical treatment to treat a disease.<sup>13</sup> Telehealth—the rectangle—has a broader definition because it includes the delivery of all health care, not just the delivery of health care by physicians.<sup>14</sup>

Telepsychiatry has the narrowest definition of the three terms and, like telemedicine, can have numerous definitions. The American Psychiatric Association defines telepsychiatry as “a specifically defined form of video conferencing that can provide psychiatric services to patients living in remote locations or otherwise underserved areas.”<sup>15</sup> North Carolina’s definition of telepsychiatry is more specific:

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10. ADAM WILLIAM DARKINS & MARGARET ANN CARY, *TELEMEDICINE AND TELEHEALTH: PRINCIPLES, POLICIES, PERFORMANCE, AND PITFALLS 2* (2000).

11. For example, telemedicine can also be defined as “healthcare carried out at a distance.” *Id.*

12. *Id.* at 3.

13. *See id.*

14. *Id.*; RASHID L. BASHSHUR & GARY W. SHANNON, *HISTORY OF TELEMEDICINE: EVOLUTION, CONTEXT, AND TRANSFORMATION 16–17* (2009). For the sake of consistency, telemedicine will be used throughout this Comment to include the delivery of all health care. The word telehealth will only be used if it is specified in the statute.

15. *Telepsychiatry*, AM. PSYCHIATRIC ASS’N, <http://www.psychiatry.org/practice/professional-interests/underserved-communities/telepsychiatry> (last visited Feb. 13, 2015).

Telepsychiatry [is t]he delivery of acute mental health or substance abuse care, including diagnosis or treatment, by means of two-way real-time interactive audio and video by a consulting provider at a consultant site to an individual patient at a referring site. The term does not include the standard use of telephones, facsimile transmissions, unsecured electronic mail, or a combination of these in the course of care.<sup>16</sup>

Both definitions involve the use of videoconferencing to connect patients to psychiatric care, and this Comment adopts the North Carolina definition because it is specifically related to the North Carolina Telepsychiatry Program.

However, because definitions only provide an abstract conception of telepsychiatry, the following explanation of the particularities of a telepsychiatric consult provides a better understanding of telepsychiatry. After a patient is admitted to the emergency department and determined to need a psychiatrist, a portable cart with a monitor, camera, and microphone is rolled into the patient's room.<sup>17</sup> A nurse then establishes "a secure web link to the psychiatric provider site and introduces the patient to an 'intake specialist' on the other end . . ."<sup>18</sup> The intake specialist, either a social worker or a masters-level psychologist, gathers information about the patient's situation and medical history.<sup>19</sup> Once the intake specialist has gathered all of the necessary information, a psychiatrist interviews the patient and makes a treatment recommendation to the referring hospital physician.<sup>20</sup> This explanation of telepsychiatry elicits particularities that are not explicit in the definition: that telepsychiatry, and more broadly telemedicine, involves the use of advanced technology and the cooperation of a number of different healthcare workers. Although telemedicine has always been associated with "advanced" technologies, it has not always involved the cooperation of other healthcare workers outside of the physician and the patient.

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16. N.C. GEN. STAT. § 143B-139.4B(a)(4) (2013).

17. Amy Ellis, *Telepsychiatry Project Delivers Mental Health Care to Remote Corners of NC*, N.C. HEALTH NEWS (Mar. 3, 2013), <http://www.northcarolinahealthnews.org/2013/03/01/telepsychiatry-project-delivers-mental-health-care-to-remote-corners-of-nc/>.

18. *Id.*

19. *Id.*

20. *Id.*

*B. The History of Telemedicine and Telepsychiatry*

Telecommunications and medicine have converged for over 125 years.<sup>21</sup> Arguably, the first intersection of telecommunications and medicine occurred in 1879 when a physician listened to an infant's cough over the telephone and determined that the child did not have croup.<sup>22</sup> Telecommunications were also used to coordinate medical supplies during the U.S. Civil War: a Union medical officer used the telegraph to request medical supplies and coordinate patient transportation.<sup>23</sup>

The use of telemedicine continued to evolve during the late nineteenth century to the mid-twentieth century. In 1905, Willem Einthoven, a Dutch physiologist and physician, transmitted and received heart sounds using the telephone.<sup>24</sup> Just five years later, in 1910, a British inventor created an "electrical stethoscope" that magnified the sounds of the heart and other internal organs using the telephone.<sup>25</sup> Since the invention of that electrical stethoscope, technology has been used to provide teleconsultations as a way of connecting remote patients to physicians.<sup>26</sup> For example, physicians used the telephone to provide medical advice, to remotely diagnose and treat sailors, and to provide instructions on how to complete a surgery when the patient was inaccessible.<sup>27</sup>

As the underlying telecommunication technology evolved, so did telemedicine. In 1955, the Nebraska Psychiatry Program, a telepsychiatry program at the Nebraska Psychiatric Institute, began to study the use of two-way, closed-circuit televisions to communicate with patients as well as to conduct psychiatric consultations and group therapy.<sup>28</sup> The study was successful and led to a 112-mile, closed-circuit link between the Nebraska Psychiatric Institute and a state mental hospital.<sup>29</sup> After the Nebraska Psychiatry Program,

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21. See BASHSHUR & SHANNON, *supra* note 14, at 135.

22. *Id.* Croup is an upper respiratory infection. Mayo Clinic Staff, *Croup Definition*, MAYO CLINIC, <http://www.mayoclinic.org/diseases-conditions/croup/basics/definition/con-20014673> (last visited Nov. 3, 2014).

23. BASHSHUR & SHANNON, *supra* note 14, at 136.

24. *Id.* at 137, 139. The heart sounds were created by attaching electrodes to the body to test heart function. *Id.* at 138.

25. *Id.* at 139.

26. See *id.* at 141 (providing examples of relevant innovations throughout the twentieth century).

27. *Id.*

28. *Id.* at 160.

29. *Id.* at 162.

telepsychiatry continued to grow in the United States<sup>30</sup> and is now endorsed by the American Psychiatric Association as “one of the most effective ways to increase access to psychiatric care for individuals living in underserved areas.”<sup>31</sup> The history of telemedicine and telepsychiatry shows that the use of telemedicine is closely linked to the underlying technology and that the reach of telemedicine expands as the technology becomes more advanced.

*C. The Technology and Application of Telemedicine and Telepsychiatry*

Unlike early telemedicine, where the equipment consisted of telephones or two-way, closed-circuit televisions,<sup>32</sup> today’s telemedicine requires multiple pieces of equipment. The technology needed for telemedicine depends on the type of telemedicine information that must be transmitted.<sup>33</sup> There are four types of telemedicine information: video, audio, still images, and text and data.<sup>34</sup> Because this Comment adopts North Carolina’s definition of telepsychiatry, which includes only videoconferencing,<sup>35</sup> it is appropriate to consider only the necessary technological equipment for videoconferencing. Generally, videoconferencing involves a dedicated videoconferencing system or a modified computer, a digital data connection, a digital video camera and tripod, and a lighting system so the consultant physician can see the patient.<sup>36</sup>

There are also four types of videoconferencing systems: (1) rollabout systems, (2) set-top systems, (3) desktop systems, and (4) public switched telephone network systems.<sup>37</sup> A rollabout system is easily transported and is comprised of a monitor that sits on top of a console that contains hardware and electrical sockets.<sup>38</sup> The second type of system, a set-top system, consists of a box containing necessary hardware that is placed on top of a television.<sup>39</sup> Similar to

30. See Avrim B. Fishkind et al., *Telepsychiatry and E-Mental Health*, in HANDBOOK OF COMMUNITY PSYCHIATRY 125, 126 (Hunter L. McQuiston et al. eds., 2012).

31. *Telepsychiatry*, *supra* note 15.

32. See *supra* notes 24–29 and accompanying text.

33. A. C. NORRIS, ESSENTIALS OF TELEMEDICINE AND TELE CARE 40 (2002).

34. *Id.*

35. See N.C. GEN. STAT. § 143B-139.4B(a)(4) (2013) (defining telepsychiatry, in part, as “including diagnosis or treatment, by means of two-way real-time interactive audio and video”).

36. DARKINS & CARY, *supra* note 10, at 253–55.

37. NORRIS, *supra* note 33, at 46–47.

38. *Id.* at 46.

39. *Id.*

the rollabout system, the set-top system is portable.<sup>40</sup> The third and fourth system types are the desktop system and the public switched telephone network system.<sup>41</sup> The desktop system is a modified personal computer, and the public switched telephone network system is the transmission of data, such as live audio and video, over a public switched telephone network.<sup>42</sup>

Additionally, there are four common applications of telemedicine.<sup>43</sup> The first common application of telemedicine is teleconsultation, which occurs when a physician videoconferences with a patient or videoconferences with another physician regarding the care of that patient.<sup>44</sup> The second application of telemedicine is tele-education, which involves a healthcare worker and an expert consultant.<sup>45</sup> Generally, “the non-expert health carer is in the same room as the patient and the expert consultant is at the other end of the remote link.”<sup>46</sup> North Carolina’s Telepsychiatry Program is an example of tele-education because the emergency department physician, who is in the same room as the patient, consults with the psychiatrist, who is in another location.<sup>47</sup> Telemonitoring is the third application of telemedicine. It “is the use of a telecommunications link to gather routine or repeated data on a patient’s condition.”<sup>48</sup> The use of the electrical stethoscope<sup>49</sup> is a function of telemonitoring. Finally, the fourth application of telemedicine is telesurgery. Telesurgery occurs either when a remotely located physician provides assistance to physicians performing a surgery or when a physician uses a robotic arm during surgery.<sup>50</sup> The underlying technology and the many applications of telemedicine are what lead to both the benefits and limitations of telemedicine and telepsychiatry.

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40. *Id.*

41. *See id.* at 46–47.

42. *Id.* A public switched telephone network is a communication network that is used by telephones, is switched—meaning that calls are routed “within and between networks by creating a dedicated end-to-end communications path”—and is public. Kevin Werbach, *No Dialtone: The End of the Public Switched Telephone Network*, 66 FED. COMM. L.J. 203, 209–10 (2014).

43. The applications of telemedicine are important to understand because this Comment argues that, in the context of the North Carolina Telepsychiatry Program, North Carolina should update its informed consent, licensure, and reimbursement statutes to include telemedicine.

44. NORRIS, *supra* note 33, at 20.

45. *Id.* at 21.

46. *Id.* at 21–22.

47. *See* N.C. GEN. STAT. § 143B-139.4B(a)(4) (2013).

48. NORRIS, *supra* note 33, at 24.

49. *See supra* note 25 and accompanying text.

50. NORRIS, *supra* note 33, at 25.

*D. The Benefits and Limitations of Telemedicine and Telepsychiatry*

Both healthcare providers and patients benefit from telemedicine and telepsychiatry. Telemedicine allows patients to have easier access to health care because it reduces the travel and time disruption for patients.<sup>51</sup> This is especially true for patients who live in rural areas and for patients who are homebound.<sup>52</sup> Telemedicine also increases access to better health care for the same reason: it allows patients to have access to specialists.<sup>53</sup> Finally, telemedicine reduces healthcare costs for hospitals because it allows hospitals to have access to specialists without having to pay those specialists full-time salaries.<sup>54</sup>

Telepsychiatry provides similar benefits and improves patient outcomes for a variety of reasons: it reduces a patient's length of stay in the emergency department because psychiatrists are readily available;<sup>55</sup> it reduces involuntary commitments because psychiatrists are able to determine whether patients are candidates for local outpatient treatment;<sup>56</sup> and it improves continuity of care "because [the] referring physician remains informed of the patient's condition."<sup>57</sup> Telepsychiatry also increases the likelihood that a patient will comply with therapy since the patient has more convenient access to mental health services.<sup>58</sup> Finally, telepsychiatry reduces "stigma associated with mental health services"<sup>59</sup> by preserving anonymity of treatment.<sup>60</sup>

Telepsychiatry and telemedicine also have limitations. First, there is the potential for poor physician-patient relationships because the patient may have reservations about confidentiality and the use of

51. *Id.* at 30–31.

52. *What is Telemedicine?*, AM. TELEMEDICINE ASS'N, [www.americantelemed.org/about-telemedicine/what-is-telemedicine](http://www.americantelemed.org/about-telemedicine/what-is-telemedicine) (last visited Nov. 3, 2014); *see also* *Telepsychiatry*, *supra* note 15.

53. *See* NORRIS, *supra* note 33, at 31.

54. *Id.* at 32.

55. Sheila F. Davies, *A Hospital Driven Telepsychiatry Initiative to Improve Patient Care and Reduce Costs*, 73 N.C. MED. J. 228, 228 (2012).

56. USING TECHNOLOGY, *supra* note 1, at 2. The reduction of involuntary commitments also has the "potential to reduce state costs associated with inpatient psychiatry treatment . . ." Davies, *supra* note 55, at 228.

57. USING TECHNOLOGY, *supra* note 1.

58. Sy Atezaz Saeed, John Diamond & Richard M. Bloch, *Use of Telepsychiatry to Improve Care for People with Mental Illness in Rural North Carolina*, 72 N.C. MED. J. 219, 220 (2011).

59. *Id.*

60. *See* DIANNE TRAVERS GUSTAFSON, KIM PRESTON & JULIA HUDSON, CTR. FOR RURAL AFFAIRS, MENTAL HEALTH: OVERLOOKED AND DISREGARDED IN RURAL AMERICA 2 (2009), available at <http://files.cfra.org/pdf/Mental-Health-Overlooked-and-Disregarded-in-Rural-America.pdf>.

the equipment.<sup>61</sup> Second, technology can often feel impersonal and may cause the patient to have less of a connection with the physician—the physician’s “bedside manner” may be lost in transmission.<sup>62</sup> Third, telemedicine requires physicians, as well as hospital staff, to undergo training in order to learn how to operate the equipment.<sup>63</sup> The hospital would also have to develop new protocol for telemedicine, causing additional logistical difficulties.<sup>64</sup> Finally, telemedicine could be unaffordable to the patient because not all health insurance companies reimburse for telemedicine consultations.<sup>65</sup> Despite the limitations to telemedicine, many healthcare entities have embraced telemedicine as a way to improve patient outcomes and decrease costs.<sup>66</sup>

## II. NORTH CAROLINA’S FORAY INTO TELEMEDICINE

### A. *Privately Funded Telemedicine Programs*

Although North Carolina’s Telepsychiatry Program is the state’s first foray into telemedicine, there are private programs already in place. North Carolina’s Telepsychiatry Program is modeled after two privately funded telemedicine programs: the East Carolina University Telemedicine Center and the Albemarle Hospital Foundation Telepsychiatry Project.<sup>67</sup>

The East Carolina University Telemedicine Center (“ECU Telemedicine Center” or “the Center”) opened in 1992 to “provide clinical telemedicine services, conduct telemedicine research, and educate healthcare providers and the public about telemedicine.”<sup>68</sup> It first provided consults with Central Prison in Raleigh<sup>69</sup> and has now

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61. NORRIS, *supra* note 33, at 33.

62. *Id.* It is difficult to have good bedside manner when, by definition, the physician is not bedside.

63. *Id.* at 34.

64. *Id.*

65. *See infra* Part III.C.

66. *See* Dehra A. Glueck, *Telepsychiatry in Private Practice*, 20 CHILD & ADOLESCENT PSYCHIATRIC CLINICS N. AM. 1, 1 (2011); Lisa K. Richardson et al., *Current Directions in Videoconferencing in Tele-Mental Health Research*, 16 CLINICAL PSYCHOL.: SCI. & PRAC. 323, 325, 328 (2009).

67. N.C. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 7, at 8.

68. *Division of Health Sciences Telemedicine Center*, E. CAROLINA U., <http://www.ecu.edu/cs-dhs/telemedicine/index.cfm> (last visited Jan. 6, 2015); *Division of Health Sciences Telemedicine Center: History*, E. CAROLINA U., [www.ecu.edu/cs-dhs/telemedicine/history.cfm](http://www.ecu.edu/cs-dhs/telemedicine/history.cfm) (last visited Jan. 6, 2015).

69. *Division of Health Sciences Telemedicine Center: History*, *supra* note 68.

expanded to include eleven sites located throughout central and eastern North Carolina.<sup>70</sup>

The Center operates in three spheres of telemedicine: clinical transactions, education, and provider consultations.<sup>71</sup> In the education sphere, the Center provides distance-learning opportunities for physicians.<sup>72</sup> In the provider consultations sphere, the Center provides consultations for those who want to practice telemedicine.<sup>73</sup> In the clinical transactions sphere, which includes scheduled, urgent, and emergent services, the Center provides initial patient assessments and diagnoses, as well as the management and follow-up of patients who were referred to specialists.<sup>74</sup> Unlike the North Carolina Telepsychiatry Program, the Center provides a wide range of services, including dermatology, cardiology, pediatrics, psychiatry, and rehabilitation medicine.<sup>75</sup>

The Center follows standard operating procedures—which, among other requirements, require obtaining patient consent—when it provides clinical services using telemedicine.<sup>76</sup> Additionally, the standard operating procedures require engineers to be present on the Center’s campus during business hours to provide technical support in case a practitioner encounters a technical issue.<sup>77</sup> Finally, practitioners who provide telemedicine consultations must sit in booths equipped with two video monitors, a video camera, speakers, a microphone, and an electronic stethoscope receiver.<sup>78</sup>

The second privately funded program after which the North Carolina Telepsychiatry Program was modeled—the Albemarle Hospital Foundation Telepsychiatry Project (“Albemarle Telepsychiatry Project” or “the Project”)—was funded in 2010 by The Duke Endowment.<sup>79</sup> The purpose of the Project is to “provide[]

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70. *Division of Health Sciences Telemedicine Center: Telehealth Network*, E. CAROLINA U., <https://www.ecu.edu/cs-dhs/telemedicine/telehealthnetwork.cfm> (last visited Jan. 6, 2015).

71. *Division of Health Sciences Telemedicine Center*, *supra* note 68.

72. *Division of Health Sciences Telemedicine Center: Distance Learning*, E. CAROLINA U., <https://www.ecu.edu/cs-dhs/telemedicine/distancelearning.cfm> (last visited Jan. 6, 2015).

73. *Id.*

74. *Division of Health Sciences Telemedicine Center: History*, *supra* note 68.

75. *Id.*

76. *Id.*

77. *Id.*

78. *Division of Health Sciences Telemedicine Center: Telehealth Network*, *supra* note 70.

79. N.C. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 7, at 9; Davies, *supra* note 55, at 228.

individuals with mental illness[es] presenting to [Emergency Departments] with psychiatric consultations via telepsychiatry, in rural areas of eastern North Carolina.”<sup>80</sup> Its primary objective is to “make psychiatric assessments readily available for all patients presenting to the emergency department with behavioral health-related issues.”<sup>81</sup> The Project currently covers twenty-nine counties and serves eighteen hospitals in eastern North Carolina.<sup>82</sup>

Like the ECU Telemedicine Center, the Albemarle Telepsychiatry Project has its own procedures.<sup>83</sup> First, a physician at the hospital where the patient is located calls the psychiatric contractor.<sup>84</sup> Then, intake specialists at the psychiatric contractor gain access to the patient’s electronic medical records to prepare for the consultation.<sup>85</sup> Finally, the consultation occurs over a secure network and takes between forty-five minutes and an hour.<sup>86</sup> After the consultation, the consultant provider makes a diagnosis and treatment recommendation.<sup>87</sup> Afterwards, the consultant provider has a follow-up telephone call with the patient’s onsite physician to answer questions and ensure the delivery of her recommendations.<sup>88</sup> In all, the entire consultation lasts between an hour and an hour and a half.<sup>89</sup>

Both the ECU Telemedicine Center and the Albemarle Telepsychiatry Project have succeeded in using technology to connect patients in underserved areas to specialists.<sup>90</sup> The successes of these programs set the stage for, and inspired, the North Carolina Statewide Telepsychiatry Program.<sup>91</sup>

#### *B. North Carolina’s Statewide Telepsychiatry Program*

On August 16, 2013, Governor Pat McCrory announced North Carolina’s Statewide Telepsychiatry Program, which became effective on January 1, 2014.<sup>92</sup> The Program addresses the shortage of mental

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80. N.C. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 7, at 9.

81. Davies, *supra* note 55, at 228.

82. N.C. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 7, at 9, 11.

83. These procedures are essential to understand because the North Carolina Telepsychiatry Program builds upon the ECU Telemedicine Program and the Albemarle Telepsychiatry Project. *See id.* at 8.

84. Davies, *supra* note 55, at 229.

85. *Id.*

86. *Id.*

87. *Id.*

88. *Id.*

89. *Id.*

90. *See* N.C. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 7, at 7–8.

91. *Id.*

92. Press Release, N.C. Dep’t of Health & Human Servs., *supra* note 6.

health services in fifty-eight of North Carolina's one hundred counties.<sup>93</sup> The purpose of the North Carolina Telepsychiatry Program is to “ensure that individuals experiencing an acute mental health or substance abuse crisis who present to an [emergency department], receive timely specialized psychiatric treatment in coordination with available and appropriate clinically relevant community resources.”<sup>94</sup> This section explores the creation and implementation of the North Carolina Telepsychiatry Program.

The North Carolina General Assembly prompted the creation of the North Carolina Telepsychiatry Program by enacting a session law that defined telepsychiatry and required the Office of Rural Health and Community Care to develop a program plan.<sup>95</sup> The statute defines the different components of telepsychiatry—the consultant site, the referring site, and the consulting provider.<sup>96</sup> These definitions allow one to gain a better sense of the General Assembly's vision of telepsychiatry. The consultant site is “[t]he hospital or other site at which the consulting provider is physically located at the time the consulting provider delivers the acute mental health or substance abuse care by means of telepsychiatry.”<sup>97</sup> The referring site is “[t]he hospital at which the patient is physically located[.]” and the consulting provider is “[a] physician or other health care provider . . . .”<sup>98</sup>

In order to provide mental health services to rural areas, the North Carolina Telepsychiatry Program “link[s] hospital emergency departments to mental health professionals who can initiate treatment for emergency department patients in mental health or substance abuse crisis.”<sup>99</sup> The Program utilizes “two-way audio and video communication technologies.”<sup>100</sup> The East Carolina University Center for Telepsychiatry will develop the provider network, as well as establish the infrastructure and guidelines for the administration of the program.<sup>101</sup> As of March 2014, twenty-three hospitals were added

93. USING TECHNOLOGY, *supra* note 1, at 1.

94. N.C. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 7, at 4.

95. Current Operations and Capital Improvements Appropriations Act of 2013, § 12A.2B(a), 2013 N.C. Sess. Laws 2013-360 (codified at N.C. GEN. STAT. § 143B-139.4B (2013)). For definitions of telepsychiatry, see *supra* notes 15–16 and accompanying text.

96. N.C. GEN. STAT. § 143B-139.4B (2013).

97. *Id.* § 143B-139.4B(a)(1).

98. *Id.* § 143B-139.4B(a)(3)–(5).

99. Press Release, N.C. Dep't of Health & Human Servs., *supra* note 6.

100. N.C. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 7, at 6.

101. Press Release, N.C. Dep't of Health & Human Servs., *supra* note 6.

to the statewide telepsychiatry network.<sup>102</sup> By July 2015, it is expected that thirty-six more hospitals will be added to the network.<sup>103</sup>

The law contains a preliminary regulatory scheme: the North Carolina Office of Rural Health and Community Care must conduct ongoing oversight of the Program.<sup>104</sup> The Office of Rural Health and Community Care must “oversee the establishment and administration”<sup>105</sup> of the Program and was delegated the power to adopt the rules necessary to ensure the health and safety of patients who receive care.<sup>106</sup> Additionally, the consulting provider<sup>107</sup> must maintain liability insurance, be licensed to practice in North Carolina, and be credentialed by all participating hospitals.<sup>108</sup> Finally, the Program follows a consultation model for liability and allows for a variety of billing and collection methods.<sup>109</sup> Although the law contains a preliminary regulatory scheme, telepsychiatry—and, more broadly, telemedicine—does not fit in the current statutory schemes for informed consent, licensure, and reimbursement.<sup>110</sup> North Carolina must update those laws in order to protect patients and become a national telemedicine model.

### III. THE STATUTORY IMPLICATIONS OF NORTH CAROLINA’S TELEPSYCHIATRY PROGRAM

Under the police powers delegated to the states through the Tenth Amendment, states have the right to protect the health and safety of their citizens.<sup>111</sup> Scholars argue that the Tenth Amendment

102. ANDREW HOLTON, TODD BRANTLEY & AISANDER DUDA, N.C. CTR. FOR PUB. POL’Y RESEARCH, TELEPSYCHIATRY IN NORTH CAROLINA: MENTAL HEALTH CARE COMES TO YOU 4 (Mar. 2014), *available at* [www.nccppr.org/drupal/sites/default/files/file\\_attachments/accomplishments/telepsychiatry.pdf](http://www.nccppr.org/drupal/sites/default/files/file_attachments/accomplishments/telepsychiatry.pdf).

103. *Id.*

104. N.C. GEN. STAT. § 143B-139.4B(c) (2013).

105. *Id.* § 143B-139.4B(b).

106. *Id.* § 143B-139.4B(d).

107. The consulting provider is the provider who has the telepsychiatric consultation with the patient. *See id.* § 143B-139.4B(a).

108. *Id.* § 143B-139.4B(a)(5); N.C. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 7, at 14. Both the consulting provider and the consultant site must maintain liability insurance. N.C. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 7, at 14.

109. N.C. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 7, at 14. There is also a study bill “that is a first step for possible enactment of legislation to require full payment by third party payors for services provided via telemedicine.” *Id.* at 15.

110. *See infra* Part III.

111. *See* U.S. CONST. amend. X; Ross D. Silverman, *Regulating Medical Practice in the Cyber Age: Issues and Challenges for State Medical Boards*, 26 AM. J.L. & MED. 255, 256 (2000).

reserves the power to regulate the practice of medicine to the states because the power “was not specifically entrusted to Congress . . . .”<sup>112</sup> States’ regulatory and statutory protections are intended to secure citizens “against the consequences of ignorance and incapacity as well as of deception and fraud.”<sup>113</sup> North Carolina’s Telepsychiatry Program implicates a multitude of statutory issues, including informed consent, licensure, and reimbursement.<sup>114</sup>

### A. *Informed Consent*

#### 1. Problems with Applying North Carolina’s Informed Consent Law to Telemedicine

Generally, a physician must obtain a patient’s informed consent before starting a treatment or procedure.<sup>115</sup> Informed consent “requires that physicians reasonably disclose to patients available treatment choices along with the material risks and benefits attendant to each alternative.”<sup>116</sup> Scholars argue that informed consent protects patient well-being and promotes patient autonomy because it allows patients to define their own sense of well-being, as well as have a voice in their health care.<sup>117</sup> There are two standards of informed consent: the professional standard and the reasonable patient standard.<sup>118</sup> The professional standard, which is applied in a majority of states,<sup>119</sup> requires the physician to disclose information that a “reasonable physician would disclose.”<sup>120</sup> The reasonable patient standard, applied in a substantial minority of states, requires the physician to disclose information that a reasonable patient would

112. Silverman, *supra* note 111, at 256.

113. *Id.* at 257 (citing *Dent v. West Virginia*, 129 U.S. 114, 122 (1889)).

114. See generally Judith F. Daar & Spencer Koerner, *Telemedicine: Legal and Practical Implication*, 19 WHITTIER L. REV. 3 (1997) (exploring the “economic and social barriers” of telemedicine).

115. See, e.g., N.C. GEN. STAT. § 90-21.13 (2013).

116. Daar & Koener, *supra* note 114, at 23.

117. See, e.g., JESSICA W. BERG ET AL., *INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE* 18–19, 24 (2d ed. 2001) (contrasting the notion of traditional information-giving, in which physicians are the ultimate decision makers, with the contemporary notion of informed consent, which allows patients to exercise their autonomy to protect their well-being as they define it).

118. R. Jason Richards, *How We Got Where We Are: A Look at Informed Consent in Colorado – Past, Present, and Future*, 26 N. ILL. U. L. REV. 69, 71 (2005).

119. Lynn D. Fleisher & Julie R. Wagner, *Telemedicine: Legal and Regulatory Issues*, in *TELEMEDICINE AND E-HEALTH LAW* § 1.04(3), at 1-60 (Law Journal Press 2014).

120. William J. McNichols, *Informed Consent Liability in a “Material Information” Jurisdiction: What Does the Future Portend?*, 48 OKLA. L. REV. 711, 717 (1995).

want to know.<sup>121</sup> Regardless of which standard a jurisdiction follows, if a physician fails to obtain informed consent, he can be held liable for negligence, battery, fraud, or assault in most states.<sup>122</sup>

Since informed consent is required for all treatments and procedures, the question is whether telepsychiatry—and, more broadly, telemedicine—falls into either of those categories. Scholars argue that telepsychiatry is a procedure because “[t]he practice of telemedicine invariably involves the diagnostic or treatment services of a distant physician, in addition to the services of the patient’s attending physician . . . .”<sup>123</sup> Additionally, telepsychiatry is the procedure of diagnosing mental health and substance abuse issues via two-way communication.<sup>124</sup> Thus, telepsychiatry should be categorized as a procedure because it is a procedure of diagnosis and because it involves diagnostic or treatment services. Therefore, informed consent should be required before the use of telepsychiatry and telemedicine.<sup>125</sup> However, only ten states mandate informed consent for telemedicine.<sup>126</sup>

North Carolina does not currently mandate informed consent for telemedicine. However, two statutes may have an impact on the informed consent requirement: sections 90-21.13 and 90-509 of the North Carolina General Statutes. Section 90-21.13 mandates

121. *Id.* North Carolina follows a hybrid of these two approaches. *See* N.C. GEN. STAT. § 90-21.13 (2013) (stating that the healthcare provider must obtain consent “in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities” and that “a reasonable person” would have a “general understanding of the procedures or treatments”).

122. Fleisher & Wagner, *supra* note 119, § 1.04(3), at 1-58.

123. Daar & Koerner, *supra* note 114, at 24; *see also* Kip Poe, *Telemedicine Liability: Texas and Other States Delve into the Uncertainties of Health Care Delivery via Advanced Communications Technology*, 20 REV. LITIG. 681, 687–88 (2001) (arguing that healthcare professionals providing treatments and procedures with the aid of telemedicine must obtain consent for that treatment or procedure as well as for the use of telemedicine).

124. *See* N.C. GEN. STAT. § 143B-139.4B(a)(4) (2013); *Telepsychiatry*, *supra* note 15.

125. *See* Fleisher & Wagner, *supra* note 119, § 1.04(3), at 1-62 (arguing that “[p]hysicians practicing telemedicine . . . are obligated to obtain informed consent from their patients”). Even if telepsychiatry and telemedicine do not fit neatly into the categories of treatment and procedure, there is a general consensus that informed consent “with information specific to telemedicine” should still be required. Diane Hoffmann & Virginia Rowthorn, *Symposium: Roundtable on Legal Impediments to Telemedicine: Legal Impediments to the Diffusion of Telemedicine*, 14 J. HEALTH CARE L. & POL’Y 1, 35 (2011). *But see* Kathleen M. Vyborny, *Legal and Political Issues Facing Telemedicine*, 5 ANNALS HEALTH L. 61, 89 (1996) (“Telemedicine itself may not be the proper focus for special disclosure.”).

126. *See infra* Part III.A.2.

“[i]nformed consent [for] health care treatment[s] or procedure[s]”<sup>127</sup> that must be “evidenced in writing . . . [and] signed by the patient or other authorized person.”<sup>128</sup> In order for the consent to be valid, the patient or authorized person must have the “capacity to make and communicate healthcare decisions.”<sup>129</sup>

There are two issues in applying North Carolina’s consent law in the telepsychiatry context: (1) the patient must have capacity to consent, and (2) treatment is not defined in the informed consent statute. North Carolina’s telepsychiatry program is for patients who come to the emergency department with mental health crises or substance abuse crises.<sup>130</sup> Those patients may not be able to consent to telepsychiatry because of capacity issues.<sup>131</sup> If the patient is unable to consent, then the physician must go through a statutory list to determine who is able to consent for the patient.<sup>132</sup> If no one is able to consent for the patient, then the attending physician must use her professional judgment to decide whether or not the patient should undergo the treatment.<sup>133</sup>

In addition to the capacity issue, “treatment” is not defined in the law.<sup>134</sup> This leaves open the question of whether the informed consent law applies to telepsychiatry and telemedicine. North Carolina defines telepsychiatry as “[t]he delivery of acute mental health or substance abuse care, including *diagnosis or treatment* . . . by a consulting provider at a consultant site to an individual patient at a referring site.”<sup>135</sup> Since North Carolina’s definition of telepsychiatry includes treatment, it seems that North Carolina’s informed consent law would apply to telepsychiatry and, by extension, to telemedicine. However, because the law does not provide a definition of treatment and does not explicitly state that telepsychiatry is a treatment, the

127. N.C. GEN. STAT. § 90-21.13 (2013).

128. *Id.* § 90-21.13(b).

129. *Id.*

130. N.C. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 7.

131. *Cf.* C. W. Van Staden & C. Krüger, *Incapacity To Give Informed Consent Owing to Mental Disorder*, 29 J. MED. ETHICS 41, 41 (defining the conditions that a mentally ill patient must meet in order to have capacity to consent to treatment). A patient or the patient’s representative must have capacity in order to consent to treatment. *See supra* note 129 and accompanying text.

132. N.C. GEN. STAT. § 90-21.13(c) (stating that a guardian, a healthcare agent, an attorney in fact, the patient’s spouse, and a majority of either the patient’s parents and children, or siblings are authorized to make medical treatments if the patient lacks capacity).

133. *Id.* § 90-21.13(c1).

134. *See id.* § 90-21.13.

135. *Id.* § 143B-139.4B(a)(4) (emphasis added).

applicability of the informed consent law to telepsychiatry is ambiguous at best.<sup>136</sup>

Another statute, section 90-509 of the North Carolina General Statutes, may have implications on whether or not informed consent is required for telepsychiatry. Section 90-509 states that the Medical Licensing Board, a state agency, “may deny, suspend or revoke any license, or otherwise discipline an applicant or holder of a license who the Board finds . . . [f]ail[ed] to obtain the informed consent of a client before taping, recording, *or permitting third-party observation* of the client’s activities.”<sup>137</sup> Telepsychiatry involves third-party observation since the consultant provider must videoconference with the patient.<sup>138</sup> Again, the application of this law to telepsychiatry is ambiguous because “third-party observation”<sup>139</sup> is not defined.

Although it would be consistent with the law in other jurisdictions,<sup>140</sup> it is unclear as to whether informed consent is required for telepsychiatry under North Carolina’s current informed consent laws. In order to protect patient autonomy and become a national model for telemedicine, North Carolina should update its current informed consent laws. In doing so, the North Carolina General Assembly should look to other states that have laws addressing informed consent for guidance.

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136. This ambiguity of the law may lead to litigation in order to determine whether informed consent is required.

137. N.C. GEN. STAT. § 90-509 (emphasis added).

138. Even if the law did not intend other providers to be considered third-party observers, there is still the possibility that non-medical workers, such as engineers, will be present during the consultation. See Marquette Gen. Hosp., *Consent to Participate in a Telemedicine Consultation*, UP HEALTH SYSTEM MARQUETTE, [ww4.mgh.org/telehealth/Shared%20Documents/TelemedicineConsent.pdf](http://ww4.mgh.org/telehealth/Shared%20Documents/TelemedicineConsent.pdf) (last updated July, 2011) (“Others may also be present during [the] consultation other than . . . [the] health care provider and consulting health care provider in order to operate the video equipment.”).

139. N.C. GEN. STAT. § 90-509. Interestingly, in order to be reimbursed by Medicaid for telepsychiatry services, North Carolina Department of Health and Human Services states that a provider “should develop policies and procedures that address . . . informed consent of consumers who receive telepsychiatric services.” MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, & SUBSTANCE ABUSE SERVS., GUIDELINES FOR THE USE OF TELEPSYCHIATRY 2 (May 6, 2010). Also, the North Carolina Medical Board did propose a policy position that stated that informed consent should be obtained “before providing care via telemedicine services.” *Policy Committee Offers New Position Statement on Telemedicine*, N.C. MED. BD. (Nov. 24, 2009), [http://www.ncmedboard.org/notices/detail/policy\\_committee\\_offers\\_new\\_position\\_statement\\_on\\_telemedicine](http://www.ncmedboard.org/notices/detail/policy_committee_offers_new_position_statement_on_telemedicine). However, the informed consent provision was not adopted in the final policy provision. See *Telemedicine*, N.C. MED. BD. (July 1, 2010), [http://www.ncmedboard.org/position\\_statements/detail/telemedicine](http://www.ncmedboard.org/position_statements/detail/telemedicine).

140. See *infra* Part III.A.2.

## 2. States Requiring Informed Consent for Telemedicine

An analysis of state laws requiring informed consent for telemedicine reveals that the laws can be placed into three different categories: (1) those that require general informed consent, (2) those that specify the information that must be included in the consent, and (3) those that require informed consent for specific telemedicine providers.<sup>141</sup> Six states have general informed consent laws for telemedicine: Arizona, California, Kentucky, Maryland, Missouri, and Texas.<sup>142</sup> These states merely require the obtainment of informed consent before the use of telemedicine services.<sup>143</sup>

Six other states—Alabama, Colorado, Louisiana, Mississippi, Nebraska, and Oklahoma—specify the information that must be included in the informed consent.<sup>144</sup> However, the states differ on the type of information required. Four of the states in this category require the disclosure of the risks and benefits of telemedicine<sup>145</sup> and/or a statement that confidentiality protocols apply.<sup>146</sup> Similarly,

141. It should be noted that a number of states mandate informed consent as a requirement for Medicaid reimbursement. CTR. FOR CONNECTED HEALTH POL'Y, STATE TELEHEALTH POLICIES AND REIMBURSEMENT SCHEDULES 7 (2014), available at [http://cchpca.org/sites/default/files/resourcess/Fifty%20State%20Medicaid%20Report.09.2014\\_1.pdf](http://cchpca.org/sites/default/files/resourcess/Fifty%20State%20Medicaid%20Report.09.2014_1.pdf). Those states are not included in this analysis because the informed consent is *only* required for insurance reimbursement. Depending on the laws of the state, it is possible that a provider could legally provide telemedicine services without informed consent. That provider—assuming he practices in a state that only requires informed consent for Medicaid reimbursement—would not be reimbursed by Medicaid.

142. ARIZ. REV. STAT. ANN. § 36-3602(A) (2009); KY. REV. STAT. ANN. § 311.5975 (West 2013); MO. REV. STAT. § 208.670.2 (2013); TEX. OCC. CODE ANN. § 111.002 (West 2012); C.A. Bill 809 (2014); MD. CODE REGS. 10.32.05.06(d)(1) (2013). These laws do not qualify informed consent so it is likely that the same general rules and standards, which are subject to state law, apply to the informed consent for telemedicine. See KY. REV. STAT. ANN. § 311.5975 (West 2013); MO. REV. STAT. § 208.670.2 (2013); TEX. OCC. CODE ANN. § 111.002 (West 2012); MD. CODE REGS. 10.32.05.06(d)(1) (2013). It should be noted that Arizona provides exceptions under certain circumstances. ARIZ. REV. STAT. ANN. § 36-3602(E).

143. See, e.g., KY. REV. STAT. ANN. § 311.5975 (West 2013).

144. See COLO. REV. STAT. § 25.5-5-320(4) (2012); NEB. REV. STAT. § 71-8505(1) (2009); OKLA. STAT. ANN. tit. 36, § 6804 (West 2009); ALA. ADMIN. CODE r. 540-X-15-08 (2014); LA. ADMIN. CODE tit. 46, § 7511 (2011); 30-2635 MISS. CODE R. § 5.3 (LexisNexis 2013). It should be noted that Alabama, Colorado, Nebraska, and Oklahoma provide an exception to informed consent in an emergency or other circumstances. COLO. REV. STAT. § 25.5-5-320(5); NEB. REV. STAT. § 71-8505(4); OKLA. STAT. ANN. tit. 36, § 6804(C)–(G); ALA. ADMIN. CODE r. 540-X-15-08.

145. Three states require disclosure of the risks and benefits of telemedicine: Alabama, Mississippi, and Oklahoma. OKLA. STAT. ANN. tit. 36, § 6804 (West 2009); ALA. ADMIN. CODE r. 540-X-15-08 (2014); 50-2635 MISS. CODE R. § 5.3 (LexisNexis 2013).

146. Four states—Colorado, Louisiana, Nebraska, and Oklahoma—require disclosure that confidentiality procedures apply. COLO. REV. STAT. § 25.5-5-320(4) (2012); NEB.

four of the states require disclosure that the patient has the right to refuse the service<sup>147</sup> and/or a statement regarding access to records from the telemedicine consult.<sup>148</sup> Finally, only two states require a statement of how the patient may access follow-up care or assistance,<sup>149</sup> and only one state requires the disclosure of the relationship between the physician, patient, and other healthcare provider.<sup>150</sup> While states appear to agree that informed consent should contain specific information, the great variation within this category indicates that there is not an agreement on the type of information that should be required. This disagreement is also reflected in the third category: specification of provider.

Four states require informed consent for specific telemedicine practitioners: Nevada, Ohio, Vermont, and Wyoming.<sup>151</sup> However, each state requires informed consent for a different telemedicine practitioner: Nevada requires informed consent for osteopaths; Vermont requires informed consent for tele-ophthalmology and teledermatology; Ohio requires informed consent for speech language pathologists; and Wyoming requires informed consent for physical therapists.<sup>152</sup> Interestingly, only Nevada and Vermont require informed consent for M.D. or M.D.-equivalent providers.<sup>153</sup>

A total of sixteen states require informed consent for telemedicine: six require general consent; six require specified information; four require informed consent for specific telemedicine practitioners; and one implements statutory exceptions to informed

REV. STAT. § 71-8505(1) (2009); OKLA. STAT. ANN. tit. 36, § 6804(A) (West 2009); LA. ADMIN. CODE tit. 46, § 7511 (2011).

147. Colorado, Louisiana, Nebraska, and Oklahoma require that the informed consent contain a statement that the patient has the right to refuse the telemedicine services. COLO. REV. STAT. § 25.5-5-320(4) (2012); NEB. REV. STAT. § 71-8505(1)(a) (2009); OKLA. STAT. ANN. tit. 36, § 6804(A) (West 2009); LA. ADMIN. CODE tit. 46, § 7511 (2011).

148. Colorado, Nebraska, and Oklahoma all require a statement regarding the access to the records from the telemedicine consult. COLO. REV. STAT. § 25.5-5-320(4) (2012); NEB. REV. STAT. § 71-8505(1) (2009); OKLA. STAT. ANN. tit. 36, § 6804(A) (West 2009).

149. Alabama and Mississippi require that the consent contain information on follow-up care or assistance. ALA. ADMIN. CODE r. 540-X-15-08 (2014); 50-2635 MISS. CODE. R. § 5.3 (LexisNexis 2013).

150. Louisiana is the only state that has this requirement. LA. ADMIN. CODE tit. 46, § 7511 (2011).

151. VT. STAT. ANN. tit. 18, § 9361 (2012); NEV. ADMIN. CODE § 633.165 (2013); OHIO ADMIN. CODE 4753-2-01 (2014); 6-62 WYO. CODE R. § 1 (LexisNexis 2012). It should be noted that Nevada provides a statutory exception to informed consent in an emergency or other situations. NEV. REV. STAT. ANN. § 633.165 (LexisNexis 2011).

152. VT. STAT. ANN. tit. 18, § 9361 (2012); NEV. ADMIN. CODE § 633.165 (2009); OHIO ADMIN. CODE 4753-2-01 (2014); 6-62 WYO. CODE R. § 1 (LexisNexis 2012).

153. NEV. REV. STAT. ANN. § 633.165 (LexisNexis 2011); VT. STAT. ANN. tit. 18, § 9361 (2012).

consent. Each category has its advantages and disadvantages, and the General Assembly would be wise to consider them all as potential updates to North Carolina's informed consent laws.

### 3. Updating North Carolina's Informed Consent Laws

North Carolina should update its informed consent laws in order to address the problem of applying the laws to telepsychiatry and telemedicine. In updating the laws, North Carolina should consider the aforementioned approaches and their advantages and disadvantages. After assessing the advantages and disadvantages, North Carolina should, at the very least, require general informed consent for telemedicine services. However, if North Carolina wants to truly protect its patients and become a leader in telemedicine, the General Assembly should adopt the "specification of information" approach to informed consent.

Each of the categories of informed consent laws—general consent, specification of information, specification of practitioner, and statutory exception—has advantages and disadvantages. For example, general informed consent laws would apply to every telemedicine practitioner but would not specify the type of information the practitioner should convey. This could be problematic because it leaves open the possibility that patients will not receive the same categories of information.<sup>154</sup> The specification of information approach would apply to every practitioner and would ensure that patients receive the same categories of information. However, a disadvantage of this approach is the potential for too much government regulation.<sup>155</sup> Unlike the previous two approaches, the specification of provider approach would require informed consent for only certain telemedicine consultations, therefore only solving part of the problem.

Even though it has disadvantages, North Carolina should, at the very least, require general informed consent. This would ensure that every patient using telemedicine would be given "sufficient

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154. Critics could argue that there is no need to specify the type of information because the current informed consent law does not do so. However, telemedicine consultations are different from face-to-face consultations because of the potential for equipment failure, the need to have non-medical personnel in the room during the consultation, and the vulnerabilities of the data network. See *infra* note 158 and accompanying text. These potential risks should be disclosed to the patient, and it is possible that not all providers would do so.

155. One could argue that requiring specific information in the informed consent controls physician judgment and negatively affects patients because the physician is unable to impart her experiences with telemedicine.

information” about telemedicine and its risks.<sup>156</sup> Additionally, the physician would be required to provide “enough information to permit a reasonable person to gain a ‘general understanding’ of both the treatment or procedure and the ‘usual and most frequent risks and hazards’ associated with the treatment.”<sup>157</sup> Examples of telemedicine-specific information include an explanation of the equipment, the possibility that non-medical staff might be present to operate the equipment, the possibility that the consultation will be recorded, the fact that the “systems are vulnerable to failure and unauthorized access,” and a description of “the features of the technology that attempt to protect against such problems.”<sup>158</sup> As was already pointed out, the general informed consent approach is problematic because it leaves open the possibility that patients would not be made aware of certain aspects of the technology. The North Carolina General Assembly could avoid this by adding general language requiring the informed consent to include the risks and benefits of telemedicine as well as the applicability of confidentiality protocols.<sup>159</sup> By implementing the “specification of information” approach to informed consent, North Carolina would ensure that every patient using telemedicine services receives enough information to make an informed decision of whether or not to use the service.

## B. Licensure

### 1. Problems with Applying North Carolina’s Licensure Laws to Telemedicine

A physician must be licensed in a state in order to practice medicine in that state.<sup>160</sup> Telemedicine complicates licensing because it allows a physician to treat easily patients located in another state. If a physician practices without a license, then she “risk[s] criminal as well as civil penalties, state disciplinary proceedings, and denial of coverage under medical malpractice insurance policies which

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156. See *Foard v. Jarman*, 326 N.C. 24, 26–27, 387 S.E.2d 162, 164 (1990) (“To meet this statutory standard [of informed consent], the health care provider must provide the patient with sufficient information about the proposed treatment and its attendant risks to conform to the customary practice of members of the same profession with similar training and experience situated in the same or similar communities.”).

157. *Id.*

158. Fleisher & Wagner, *supra* note 119, § 1.04(3)(c)(ii)(A), at 1-61.

159. These two categories are the types of information required by a majority of states within the specification of information category. See *supra* notes 145–46 and accompanying text.

160. Fleisher & Wagner, *supra* note 119, § 1.02(2)(a), at 1-11.

generally require licensure as a condition of coverage.”<sup>161</sup> The issue of licensure has two sides. Proponents argue that licensure protects the patient,<sup>162</sup> while opponents argue that statutes that limit licensure to in-state physicians threaten “the future expansion of interstate, national and international telemedicine activities . . . .”<sup>163</sup>

North Carolina requires licensure and registration for those who practice medicine within the state.<sup>164</sup> The practice of medicine is defined as “[t]he performance of any act, within or without this State, . . . by use of any *electronic* or other means, including the Internet or telephone.”<sup>165</sup> However, North Carolina has a licensure and registration exception for a “nonregistered reputable physician or surgeon who . . . on an irregular basis . . . consult[s] with a resident registered physician or . . . consult[s] with personnel at a medical school about educational or medical training.”<sup>166</sup> Thus, according to the North Carolina licensure statutes, a practitioner who wishes to regularly practice telemedicine in the state must be licensed by North Carolina.<sup>167</sup> The North Carolina Board of Medicine has given more guidance on this issue, stating that the practice of medicine occurs in the state where the patient is located and licensees do not have to live in North Carolina as long as they have a valid North Carolina license.<sup>168</sup> This necessarily means that physicians with an out-of-state license who wish to establish a telemedicine practice in North Carolina must obtain a North Carolina license, a process that is time-consuming and burdensome.<sup>169</sup> In order to become a national leader in telemedicine, North Carolina should open its borders to out-of-state physicians while maintaining patient safety.

161. *Id.* § 1.02(2)(b)(i), at 1-13.

162. See Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from Their Physicians*, 55 U. PITT. L. REV. 291, 382 (1994).

163. Fleisher & Wagner, *supra* note 119, § 1.02(2)(b)(i), at 1-13.

164. N.C. GEN. STAT. § 90-18(a) (2013) (“No person shall perform any act constituting the practice of medicine or surgery, as defined in this Article, or any of the branches thereof, unless the person shall have been first licensed and registered so to do in the manner provided in this Article.”).

165. *Id.* § 90-1.1(5)(f) (emphasis added).

166. *Id.* § 90-18(c)(11).

167. North Carolina makes a distinction between regular consultations and irregular consultations. The statute makes an exception for irregular consultations. See *id.*; see also *Telemedicine*, *supra* note 139.

168. *Telemedicine*, *supra* note 139.

169. Christine Vestal, *Expanding Telemedicine Beyond State Borders*, USA TODAY (Mar. 7, 2014), <http://www.usatoday.com/story/news/nation/2014/03/07/stateline-telemedicine-expansion/6159775/>.

## 2. Potential Legislative Solutions

Seventeen states have either directly or indirectly addressed the issue of licensure and telemedicine.<sup>170</sup> An analysis of the statutes reveals that they can be divided into four categories: (1) those that grant telemedicine licenses to out-of-state physicians, (2) those that grant medical licenses to any out-of-state physician, (3) those that restrict the issuance of medical licenses to out-of-state physicians from specific geographic areas, and (4) those that exempt specific physicians from the license requirement.

Currently, eight states require physicians who practice telemedicine to have a telemedicine license—Louisiana, Montana, Nevada, New Mexico, Ohio, Oklahoma, Tennessee, and Texas—but each state has different requirements for the issuance of a telemedicine license.<sup>171</sup> Four states have adopted the most basic requirement that the out-of-state physician have a “full and unrestricted license”<sup>172</sup>: Louisiana, New Mexico, Ohio, and Tennessee.<sup>173</sup> Other states, such as Montana and Texas, have more stringent requirements—physicians must be board-certified in their specialty or be eligible to take the board certification examination in order to receive a telemedicine license.<sup>174</sup> Finally, neither Nevada nor Oklahoma explicitly state any requirements for the issuance of the

170. ALA. CODE §§ 34-24-502, 34-24-507 (LexisNexis 2011); CONN. GEN. STAT. ANN. § 20-12 (West 2012); HAW. REV. STAT. ANN. § 453-2(b)(7) (LexisNexis 2011); LA. REV. STAT. ANN. § 37:1276.1 (2013); MD. CODE ANN., HEALTH OCC. § 14-302(4) (LexisNexis 2012); MINN. STAT. ANN. § 147.032 (West 2013); MISS. CODE ANN. § 73-25-34 (West 2012); MONT. CODE ANN. § 37-3-343 (2011); N.M. STAT. ANN. § 61-6-11.1 (West 2012); OHIO REV. CODE ANN. § 4731.296(c) (LexisNexis 2012); OR. REV. STAT. § 677.139 (2007); 63 PA. CONS. STAT. ANN. § 422.34(a) (West 2012); TENN. CODE ANN. § 63-6-209(b) (2012); WASH. REV. CODE ANN. § 18.71.030(6) (West 2013); 2013 Nev. Stat. 2010 (to be codified at NEV. REV. STAT. §§ 630.261, 630.2645); 22 TEX. ADMIN. CODE § 172.12 (2013).

171. See LA. REV. STAT. ANN. § 37:1276.1 (2013); MONT. CODE ANN. § 37-3-343 (2011); N.M. STAT. ANN. § 61-6-11.1 (West 2012); OHIO REV. CODE ANN. § 4731.296(c) (LexisNexis 2012); TENN. CODE ANN. § 63-6-209(b) (2012); S.B. 327, 2013 Leg., 77th Sess. (Nev. 2013); OKLA. ADMIN. CODE § 435:10-7-13(a) (2014); 22 TEX. ADMIN. CODE § 172.12 (2013); see also OKLA. STAT. ANN. tit. 59, § 633 (West 2009) (referencing telemedicine licenses). While New Mexico currently requires a telemedicine license, the statute will be repealed on July 1, 2016. N.M. STAT. ANN. §§ 61-6-11.1, 61-6-35 (West 2012).

172. LA. REV. STAT. ANN. § 37:1276.1 (2013).

173. *Id.*; N.M. STAT. ANN. § 61-6-11.1 (West 2012); OHIO REV. CODE ANN. § 4731.296(c) (LexisNexis 2012); TENN. CODE ANN. § 63-6-209(b) (2012).

174. MONT. CODE ANN. § 37-3-343(2) (2011); TEX. OCC. CODE § 151.056 (West 2013); 22 TEX. ADMIN. CODE § 172.12 (2013). Texas also requires passage of the Texas Medical Jurisprudence Examination. TEX. OCC. CODE § 151.056 (West 2013); 22 TEX. ADMIN. CODE § 172.12 (2013).

telemedicine license.<sup>175</sup> The variation within this category is indicative of a larger theme: that states agree on the broad action but do not agree on the specific elements of that action.<sup>176</sup>

Six states have statutes that permit out-of-state physicians to obtain medical licenses.<sup>177</sup> As with the “telemedicine license” category, an analysis of the laws reveals that they can be further characterized into three subgroups based on their type of license law: those that require the absence of disciplinary measures; those that require an in-state physician’s request; and those that prohibit the physician from practicing within the state. Four out of the six states—Alabama, Connecticut, Minnesota, and Oregon—require that the applicant physician either have not had any disciplinary measures taken against him in his home state<sup>178</sup> or have not had any pending disciplinary measures against him in his home state.<sup>179</sup> Only Mississippi falls into the second category of laws, which require an in-state physician to request the treatment, evaluation, or opinion of an out-of-state physician.<sup>180</sup> The last subgroup, which includes Washington and Minnesota, requires that the physician not practice or receive calls within the state.<sup>181</sup> Similar to the states that require telemedicine licenses, the variation within this category is further evidence of broad agreement about action but disagreement as to implementation.

Two states fall into the final two categories of licensing regulations for out-of-state physicians.<sup>182</sup> Pennsylvania restricts the

175. S.B. 327, 2013 Leg., 77th Sess. (Nev. 2013); OKLA. ADMIN. CODE § 435:10-7-13(a) (2014).

176. See *infra* notes 177–81 and accompanying text for another example of disagreement regarding implementation of a broader agreed-upon action.

177. The six states within this category are Alabama, Connecticut, Minnesota, Mississippi, Oregon, and Washington. ALA. CODE §§ 34-24-502, 34-24-507 (LexisNexis 2011); CONN. GEN. STAT. ANN. § 20-12 (West 2012); MINN. STAT. ANN. § 147.032 (West 2013); MISS. CODE ANN. § 73-25-34 (West 2012); OR. REV. STAT. § 677.139 (2007); WASH. REV. CODE ANN. § 18.71.030(6) (West 2013).

178. ALA. CODE § 34-24-502(b)(2) (LexisNexis 2011); MINN. STAT. ANN. § 147.032 (West 2013); OR. REV. STAT. § 677.139 (2007).

179. CONN. GEN. STAT. ANN. § 20-12 (West 2012).

180. See MISS. CODE ANN. § 73-25-34 (West 2012). Mississippi also requires the Mississippi physician to have an already established physician-patient relationship with the patient. *Id.*

181. MINN. STAT. ANN. § 147.032(3) (West 2013); WASH. REV. CODE ANN. § 18.71.030(6) (West 2013). Although this is similar to a telemedicine license, it is included in the issuance of a license to any out-of-state physician category because the statute does not use the words “telemedicine license” or “telemedicine certificate.”

182. MD. CODE ANN., HEALTH OCC. § 14-302(4) (LexisNexis 2012); 63 PA. CONS. STAT. ANN. § 422.34(a) (West 2012).

issuance of licenses to out-of-state physicians from adjoining states.<sup>183</sup> Similarly, Maryland exempts physicians who live in adjoining states from the license requirement if the “physician does not have an office or regularly appointed place [in Maryland] to meet patients,” and the adjoining state grants reciprocity.<sup>184</sup>

The broad disagreement among states on how to address the issue of telemedicine and licensure has led some scholars to argue that there should be regional licensure laws or a national licensure law.<sup>185</sup> A national licensure law would grant a single license to telemedicine practitioners using standardized criteria and “would put the administration and licensing authority for telemedicine in the hands of the federal government.”<sup>186</sup> Proponents argue that this type of system would be less burdensome for the physician<sup>187</sup> and would remove “state licensure laws [that] are fragmented and uncoordinated. . . .”<sup>188</sup> Opponents argue that a national licensure law would eliminate states’ Tenth Amendment right to regulate health care.<sup>189</sup> They also argue that a national licensure law would cause a loss of state revenue and that disciplinary actions would be difficult to undertake.<sup>190</sup>

An alternative to a national licensure law is regional licensure laws, which would allow physicians to be licensed in states that are in the same region as their state of residence.<sup>191</sup> Essentially, states within the same region would adopt the same licensure laws.<sup>192</sup> Leadership of the regional licensure laws would come from the various governors’ groups, such as the Southern Governors Association and the Western Governors Association.<sup>193</sup> Due to the widespread disagreement among states and scholars on the best course of action for including

183. 63 PA. CONS. STAT. ANN. § 422.34(a) (West 2012).

184. MD. CODE ANN., HEALTH OCC. § 14-302(4) (LexisNexis 2012).

185. See Mark A. Cwiek et al., *Telemedicine Licensure in the United States: The Need for a Cooperative Regional Approach*, 13 TELEMEDICINE & E-HEALTH 141, 143 (2007); Peter D. Jacobson & Elizabeth Selvin, *Licensing Telemedicine: The Need for a National System*, 6 TELEMEDICINE J. & E-HEALTH 429, 433 (2000); Nancy Luhn, Note, *Medical Licensure and Telemedicine: Necessity or Barrier?*, 25 SUFFOLK TRANSNAT’L L. REV. 165, 180 (2001).

186. Jacobson & Selvin, *supra* note 185, at 433; Luhn, *supra* note 185, at 180.

187. Luhn, *supra* note 185, at 180.

188. Jacobson & Selvin, *supra* note 185, at 431.

189. Cwiek et al., *supra* note 185, at 143; see *supra* notes 111–112 and accompanying text.

190. Luhn, *supra* note 185, at 180–81.

191. See Cwiek et al., *supra* note 185, at 144–45.

192. See *id.*

193. *Id.* at 144.

telemedicine in state licensure laws,<sup>194</sup> the North Carolina General Assembly should consider the advantages and disadvantages of each approach when updating North Carolina's licensure law.

### 3. Updating North Carolina's Licensure Laws

As already explained, North Carolina's licensure laws prohibit the regular practice of telemedicine by out-of-state physicians.<sup>195</sup> In order to update its laws to encourage telemedicine, North Carolina has six options: the General Assembly could (1) create a telemedicine license, (2) allow any out-of-state physician to apply for a medical license, (3) allow out-of-state physicians from a specific geographic location to apply for medical licenses, (4) allow only certain out-of-state specialists to apply for medical licenses, (5) lobby for regional licensure laws, and (6) lobby for national licensure laws.<sup>196</sup> However, the aforementioned approaches differ on ease of implementation and attractiveness to telemedicine practitioners. In order to move to the forefront of the telemedicine movement, North Carolina should open its borders to telemedicine practitioners by implementing a telemedicine license.

Each of the six options for updating North Carolina's licensure laws has advantages and disadvantages. For example, a telemedicine license would attract new telemedicine practitioners, protect patients, minimize costs to physicians, and allow North Carolina to continue to regulate tightly the practice of medicine.<sup>197</sup> However, implementing a telemedicine licensing scheme may be costly to the state as it requires the development of new requirements. The "any physician" licensure approach also has the potential to attract telemedicine practitioners to North Carolina but could be costly to both physicians and the

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194. Carl F. Ameringer, *State-Based Licensure of Telemedicine: The Need for Uniformity but Not a National Scheme*, 14 J. HEALTH CARE L. & POL'Y 55, 60–61 (2011) ("Despite widespread agreement that something should be done to overcome barriers to interstate practice, no clear consensus has been reached about how to proceed. Some individuals and organizations advocate a national licensure scheme for telemedicine; others support various forms of endorsement, mutual recognition, and reciprocity; still others, such as the Federation [of State Medical Boards], have proposed a special or limited license and, more recently, a form of expedited endorsement." (footnotes omitted)).

195. See N.C. GEN. STAT. § 90-18(c)(11) (2013); *supra* Part III.B.1.

196. See *supra* Part III.B.2 for an explanation of each legislative solution.

197. Jacobson & Selvin, *supra* note 185, at 435 (stating that a special license, such as a telemedicine license, "preserve[s] state authority to enforce clinical standards of care and physician accountability" and "protects patient while minimizing costs to physicians").

state.<sup>198</sup> The approaches that restrict licensure to physicians from a specific geographic area or to a specific specialty, would allow North Carolina to regulate tightly out-of-state telemedicine practitioners.<sup>199</sup> However, these options would not allow for rapid expansion of telemedicine because very few out-of-state telemedicine practitioners would be allowed to practice in the state. Finally, both the national licensure law and the regional licensure laws would remove the majority of the licensure barriers from telemedicine and allow North Carolina to attract telemedicine practitioners.<sup>200</sup> However, they both would require significant political agreement and, until that agreement was reached, North Carolina would be left without any updated licensure laws.

Given the advantages and disadvantages of each potential solution, North Carolina should implement a telemedicine license for all out-of-state telemedicine practitioners. Although this option may be costly to the state, it allows North Carolina to attract telemedicine practitioners while maintaining its authority “to enforce clinical standards of care and physician accountability.”<sup>201</sup> If North Carolina wanted to provide even greater protection to its patients, it could follow the lead of Montana and Texas and require that telemedicine licensure applicants be board certified.<sup>202</sup> Both options would attract new telemedicine practitioners to North Carolina and move the state to the forefront of the telemedicine movement.

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198. *Cf. id.* at 434 (“[O]btaining a second license is cumbersome, and it requires additional fees.”).

199. *Cf. id.* at 435 (stating that a special license, such as a telemedicine license, “preserves state authority to enforce clinical standards of care and physician accountability”).

200. *See supra* Part III.B.2.b.

201. Jacobson & Selvin, *supra* note 185, at 435. The argument could be made that the costs outweigh the benefits of this option. However, telemedicine can increase access to care, which is especially beneficial for rural patients. *See Vestal, supra* note 169. Additionally, state medical boards that actively restrict out-of-state physicians from obtaining licenses to practice may be engaging in anti-competitive behavior. *See id.*

202. *See* note 174 and accompanying text. Board certification would further protect patients because it requires the physician to undergo additional testing and peer evaluations. *Board Certification and Maintenance of Certification*, AM. BD. OF MED. SPECIALTIES, <http://www.abms.org/board-certification/> (last visited Oct. 29, 2014). It can be argued that board certification protects the patient because it “serve[s] as [an] important marker[] for a higher standard of care.” *Id.*

C. *Reimbursement*

1. Problems with Reimbursement for Telemedicine Services in North Carolina

a. *Federal, State, and Voluntary Reimbursement*

Traditionally, insurance companies have not reimbursed costs associated with telemedicine.<sup>203</sup> Reimbursement is an integral part of the success of telemedicine because it determines whether or not telemedicine initiatives are sustainable.<sup>204</sup> Indeed, in North Carolina “[p]ayment for services from [North Carolina] Medicaid, state appropriated funds and third party/commercial payors are critical for a sustainable model to include indigent care.”<sup>205</sup> In order for telemedicine to be successful, Medicare, Medicaid, and private insurers need to offer reimbursement for telemedicine services.

Medicare and, depending on the state, Medicaid both reimburse providers for certain types of telemedicine services.<sup>206</sup> Medicare reimbursement “does not extend to all reasonable uses of telemedicine,”<sup>207</sup> as it is limited to rural or underserved areas and only covers interactive two-way telecommunications between a patient and a healthcare provider.<sup>208</sup> Unlike Medicare, Medicaid reimbursement for telemedicine is state dependent because the program is run by the states “within the boundaries set by the federal government.”<sup>209</sup> Only six states, Connecticut, Iowa, Massachusetts, New Hampshire, New Jersey, and Rhode Island, do not have any form of reimbursement.<sup>210</sup> Additionally, forty-six states only reimburse for telemedicine consults that take place over live video, excluding reimbursement for other

203. Kristen Rabe Smolensky, *Telemedicine Reimbursement: Raising the Iron Triangle Plateau*, 13 HEALTH MATRIX 371, 372 (2003).

204. See Julia Alder-Milstein, Joseph Kvedar & David W. Bates, *Telehealth Among US Hospitals: Several Factors, Including State Reimbursement and Licensure Policies, Influence Adoption*, 33 HEALTH AFFAIRS 207, 207 (2014) (“Finally, and perhaps most importantly, state policies affecting reimbursement and regulation likely affect how interested hospitals are in offering telehealth services.”).

205. N.C. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 7, at 15.

206. See CTRS. FOR MEDICARE & MEDICAID SERVS., TELEHEALTH SERVICES 1–2 (2014); Smolensky, *supra* note 203, at 378–79.

207. Smolensky, *supra* note 203, at 373.

208. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 206, at 1–2. Medicare reimbursement is problematic because it excludes store-and-forward technology as well as a number of providers who practice in areas that do not qualify as underserved. Smolensky, *supra* note 203, at 378.

209. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 206, at 1–2; Smolensky, *supra* note 203, at 378–79.

210. CTR. FOR CONNECTED HEALTH POL’Y, *supra* note 141, at 5–6.

types of telemedicine, such as store-and-forward services and remote patient monitoring.<sup>211</sup>

Private insurance companies, such as BlueCross BlueShield and Aetna, are beginning to cover telemedicine, either voluntarily or because of statutory compulsion.<sup>212</sup> Only “twenty-one states and the District of Columbia . . . have active laws that govern private payer telehealth reimbursement policies.”<sup>213</sup> One other state, Arizona, has passed reimbursement laws that have not yet taken effect.<sup>214</sup> North Carolina is not among the states that require private payer reimbursement, even though the state’s Medicaid program reimburses certain providers for telemedicine services.

*b. Reimbursement in North Carolina*

North Carolina restricts Medicaid reimbursement for telemedicine. In order for the provider to be reimbursed, the following requirements must be met:

[T]he procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the recipient’s needs; . . . no equally effective and more conservative or less costly treatment is available statewide; . . . and [the procedure] is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary’s caretaker, or the provider.<sup>215</sup>

Additionally, the use of telemedicine must be medically necessary.<sup>216</sup> Finally, the consultant site “must be of sufficient distance” from a patient “who does not have readily available access to such specialty services.”<sup>217</sup>

North Carolina does not mandate private insurance reimbursement for telemedicine.<sup>218</sup> However, BlueCross BlueShield of North Carolina voluntarily reimburses for telemedicine

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211. *Id.*

212. Smolensky, *supra* note 203, at 380.

213. CTR. FOR CONNECTED HEALTH POL’Y, *supra* note 141, at 8.

214. *Id.*

215. N.C. DIV. OF MED. ASSISTANCE, TELEMEDICINE AND TELEPSYCHIATRY MEDICAID AND HEALTH CHOICE CLINICAL COVERAGE POLICY NO: 1H, at 3 (Nov. 15, 2013), available at [www.ncdhhs.gov/dma/mp/1H.pdf](http://www.ncdhhs.gov/dma/mp/1H.pdf).

216. *Id.*

217. *Id.* at 4.

218. *State Coverage for Telehealth Services*, NAT’L CONF. OF STATE LEGS., <http://www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx> (last visited Jan. 6, 2015).

consultations when “it is determined . . . medically necessary because . . . medical criteria and guidelines . . . are met.”<sup>219</sup> In order to meet the criteria, (1) the patient must be present during the consultation, (2) the examination must be “under the control of the consulting practitioner,” (3) the services must be “medically appropriate and necessary,” (4) the consulting site must be “of a sufficient distance from the originating site to provide services to patients who do not have readily available access to such specialty services,” (5) the consultation must use “an interactive audio and video telecommunications system,” and (6) record of the communication must be placed in “the patient’s medical record.”<sup>220</sup> BlueCross BlueShield of North Carolina does not cover “[i]nterpretation of lab or radiology services by providers who are not licensed in the state of North Carolina.”<sup>221</sup> This limitation, along with the aforementioned requirements, indicates that BlueCross BlueShield will not reimburse store-and-forward services or any teleconferencing services that are provided to homebound patients.

Although North Carolina does not mandate reimbursement of telemedicine services by private insurance companies, the North Carolina General Assembly passed the “2013 [North Carolina] Telemedicine study bill that is a first step for possible enactment of legislation to require full payment by third party payors for services provided via telemedicine.”<sup>222</sup> The study bill requires the Joint Legislative Oversight Committee on Health and Human Services to study the use of telemedicine to increase access to care, reduce health disparities, and provide more efficient care.<sup>223</sup> Additionally, the bill requires the Department of Health and Human Services to refrain from adopting or amending Medicaid or Health Choice<sup>224</sup> to include a provision requiring pre-approval of telemedicine or a provision that limits coverage based on the distance between the referring site and the consulting site.<sup>225</sup> The bill was referred to the Committee on Rules and Operations of the Senate, where it remained without further

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219. BLUECROSS BLUESHIELD OF NORTH CAROLINA, CORPORATE MEDICAL POLICY: TELEMEDICINE 1 (Apr. 2013), *available at* [www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/telemedicine.pdf](http://www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/telemedicine.pdf).

220. *Id.* at 2.

221. *Id.* at 1.

222. N.C. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 7, at 15.

223. H.B. 704 § 1.a, 2013 Sess. (N.C. 2013).

224. Health Choice is North Carolina’s insurance program for low-income children. *What is Health Choice for Children*, N.C. DIV. OF MED. ASSISTANCE, <http://www.ncdhhs.gov/dma/healthchoice/> (last visited Feb. 16, 2014).

225. H.B. 704 § 2.b, 2013 Sess. (N.C. 2013).

action.<sup>226</sup> In order for North Carolina to ensure the sustainability of the North Carolina Telepsychiatry Program and be at the forefront of the telemedicine movement, it should follow the lead of other states and require reimbursement from private health insurance companies.

## 2. States that Require Reimbursement for Telemedicine

An analysis of state laws reveals that there are twenty-one states that have statutes requiring private insurance companies to reimburse telemedicine services.<sup>227</sup> Although most of the statutes do not contain the same language, they can be divided into three groups based on content: (1) those that require coverage with no limitations; (2) those that require the telemedicine service recipient to be located in a rural area; and (3) those that require a physician to be physically present with the patient during the telemedicine service at the originating site. Finally, some states choose to mandate the amount of reimbursement while others merely mandate reimbursement.<sup>228</sup>

Nineteen states fall into the first category: states that require coverage, therefore reimbursement, with no limitations other than those already put in place by the health insurance plan.<sup>229</sup> An example of a statute that falls within this category is Texas's statute, which mandates that an insurer cannot exclude telemedicine services "solely

226. N.C. MED. SOC'Y, 2013 LEGISLATIVE SUMMARY 41 (2013), available at [http://www.ncmedsoc.org/government\\_affairs/legislative.html](http://www.ncmedsoc.org/government_affairs/legislative.html); *House Bill 704*, N.C. GEN. ASSEMB., <http://www.ncleg.net/gascripts/BillLookUp/BillLookUp.pl?Session=2013&BillID=H704> (last visited Oct. 26, 2014). The bill passed the House, but it was not debated in the Senate before the end of the 2013–14 legislative session. See *House Bill 704*, *supra*. Although the bill proposed that the Committee be required to make recommendations by April 1, 2014, the bill failed to pass, so the study will not be conducted. See H.B. 704 § 1.b, 2013 Sess. (N.C. 2013).

227. CTR. FOR CONNECTED HEALTH POL'Y, *supra* note 141, at 8.

228. *Cf. id.* ("[S]ome private payer laws require that the reimbursement amount for a telehealth-delivered service be equal to the amount that would have been reimbursed, had the same service been delivered in-person; however, this is not always the case.").

229. The nineteen states are California, Georgia, Hawaii, Kentucky, Maine, Maryland, Michigan, Mississippi, Missouri, Montana, New Hampshire, New Mexico, New York, Oklahoma, Oregon, Tennessee, Texas, Vermont, and Virginia. CAL. HEALTH & SAFETY CODE § 1374.13(c) (West 2012); GA. CODE ANN. § 33-24-56.4(d) (2013); HAW. REV. STAT. ANN. § 431:10A-116.3(b) (LexisNexis 2011); KY. REV. STAT. ANN. § 304.17A-138(1) (LexisNexis 2011); ME. REV. STAT. ANN. tit. 24-A, § 4316 (2012); MD. CODE ANN., INS. § 15-139(c) (LexisNexis 2012); MICH. COMP. LAWS § 500.3476(1) (2013); MISS. CODE ANN. § 83-9-351(2) (2014); MO. REV. STAT. § 376.1900.2 (2013); N.H. REV. STAT. ANN. § 415-J:3(II) (LexisNexis 2012); OKLA. STAT. ANN. tit. 36, § 6803(A) (West 2009); OR. REV. STAT. § 743A.058(2) (2007); TEX. INS. CODE ANN. art. 1455.004 (West 2009); VT. STAT. ANN. tit. 8, § 4100k(a) (2012); VA. CODE ANN. § 38.2-3418.16(c) (2014); S.B. 270, 63rd Legis., Reg. Sess. (Mont. 2013); S.B. 69, 2013 Reg. Sess. (N.M. 2013); S.B. 7852, 2014 Legis., Reg. Sess. (N.Y. 2014); H.B. 1895, 108th Gen. Assemb., Reg. Sess. (Tenn. 2014).

because the service is not provided through a face-to-face consultation.”<sup>230</sup> The statute also mandates that “[t]he amount of the deductible, copayment, or coinsurance . . . not exceed the amount of the deductible, copayment, or coinsurance required for a comparable medical service provided through a face-to-face consultation.”<sup>231</sup> This is one of the few subgroups where there is widespread agreement among the states regarding the implementation of a broader goal.<sup>232</sup>

Two states—Arizona and Colorado—fall into the second category of statutes that require the telemedicine service recipient to be located in a rural area.<sup>233</sup> However, the two states disagree on the definition of “rural.” While both states require the recipient to be located in a rural area, Arizona implements a broader definition of rural:

A “rural region” means either: an area located in a county with a population of less than nine hundred thousand persons, [or] a city or town that is located in a county with a population of nine hundred thousand persons or more and whose nearest boundary is more than thirty miles from the boundary of a city that has a population of five hundred thousand persons or more.<sup>234</sup>

Colorado has a narrower definition of rural, defining it as “a county with one hundred fifty thousand or fewer residents . . . [that] has the technology necessary for the provisions of telemedicine.”<sup>235</sup> Because of its broader definition, Arizona’s statute, as compared to Colorado’s statute, has the potential to require reimbursement for more telemedicine patients. However, the statutes in both Arizona and Colorado will impact fewer patients than the states within the previous category.

Louisiana is the only state that falls into the final category of reimbursement statutes: those that require reimbursement for the physician that is physically present at the originating site of the telemedicine consultation. Louisiana’s statute requires that “[t]he

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230. TEX. INS. CODE ANN. art. 1455.004 (West 2009).

231. *Id.* art. 1455.004(b).

232. The other subgroup is states that require general informed consent before the provision of telemedicine services. *See supra* notes 141–43 and accompanying text. Additionally, it could be argued that the categories that consist of one state do not constitute disagreement. However, it is difficult to argue that there is agreement because the category consists of only one state.

233. COLO. REV. STAT. § 10-16-123(2) (2012); S.B. 1353, 51st Leg., 1st Reg. Sess. (Ariz. 2013).

234. S.B. 1353, 51st Leg., 1st Reg. Sess. (Ariz. 2013).

235. COLO. REV. STAT. § 10-16-123(2) (2012).

payment, benefit, or reimbursement to such a licensed physician at the originating facility or terminus shall not be less than seventy-five percent of the reasonable and customary amount of payment, benefit, or reimbursement which that licensed physician receives for an intermediate office visit.”<sup>236</sup> This is the most restrictive category of statutes because the requirement for a physician to be physically present at the originating site effectively excludes the use of telemedicine to reach homebound patients. When formulating a reimbursement parity law, the General Assembly should consider each category’s advantages and disadvantages.

### 3. Updating North Carolina’s Telemedicine Reimbursement Laws

North Carolina currently does not require insurance parity for telemedicine.<sup>237</sup> A law requiring insurance parity will ensure the sustainability of the North Carolina Telemedicine Program as well as future telemedicine endeavors.<sup>238</sup> North Carolina could take any of the three aforementioned approaches—no limitations, rural patients only, or physician must be present. However, each approach has advantages and disadvantages, and each signals something different regarding the acceptance of telemedicine. At the very least, North Carolina should formulate an insurance parity law for rural patients. However, if North Carolina wants to be at the forefront of the telemedicine movement, it should require insurers to cover all services appropriately provided through telemedicine.

Each of the three approaches implicitly contains signals about the acceptance of telemedicine and has advantages and disadvantages. A reimbursement law that contains no limitations would cover all patients with health insurance who use telemedicine services. It would also reduce the cost to the patient and allow the provider to provide indigent care.<sup>239</sup> Additionally, the no limitations approach signals the widespread acceptance of telemedicine.<sup>240</sup> The

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236. LA. REV. STAT. ANN. § 22:1821(F)(1) (2013).

237. See *supra* notes 218–26 and accompanying text.

238. With regards to the North Carolina Telepsychiatry Program, private insurance reimbursement would allow the Program to be sustainable while including indigent care. See *supra* note 204 and accompanying text. With regards to telemedicine in general, reimbursement would attract new providers because it would allow them to be paid for their services. Cf. Alder-Milstein, Kveda & Bates, *supra* note 204, at 207 (“Finally, and perhaps most importantly, state policies affecting reimbursement and regulation likely affect how interested hospitals are in offering telehealth services.”).

239. TL Wenger et al., *Telemedicine for Genetic and Neurologic Evaluation in the Neonatal Intensive Care Unit*, 34 J. PERINATOLOGY 234, 238 (2014).

240. Kristen Jakobsen Osenga, Note, *Space-Age Medicine, Stone-Age Government: How Medicare Reimbursement of Telemedicine Services is Depriving the Elderly of Quality*

disadvantage to this approach, however, is that some may argue that it involves too much regulation and could create a slippery slope of future regulations of the insurance market. The advantage of the rural patient approach is that it would impact some of the patients who receive telemedicine services and some of the providers who provide telemedicine services. This approach would require North Carolina to define “rural” and would exclude patients and providers who receive and provide telemedicine in non-rural areas. Additionally, this approach would signal the acceptance of telemedicine as a tool to reach rural areas—because reimbursement is only provided for rural areas—and would not signal widespread acceptance. Finally, the physician present approach would solve the problem of reimbursement for patients and providers within the North Carolina Telepsychiatry Program because the Program “link[s] hospital emergency departments to mental health professionals who can initiate treatment for emergency department patients in mental health or substance abuse crisis.”<sup>241</sup> However, this approach would exclude other uses of telemedicine, such as to reach homebound patients, because there would not be a physician physically present within the home of the patient.

North Carolina should, at the very least, adopt the “rural only” approach because it would allow the use of telemedicine to reach patients that most likely do not have ready access to needed specialists.<sup>242</sup> If North Carolina adopted this approach, the General Assembly would have to define “rural.” There are three ways in which the General Assembly could define “rural.” It could: (1) model its definition of rural after Arizona or Colorado, (2) use federal guidelines for determining health professional shortage areas, or (3) use the federal definition of rural.<sup>243</sup> Of these three options, the best

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*Medical Treatment*, 8 ELDER L.J. 151, 154 (2000) (“[T]he health care community will not embrace telemedicine as a medium for medical service delivery until it is accepted for coverage under government reimbursement programs . . . and private health insurance.”).

241. Press Release, N.C. Dep’t Health & Human Servs., *supra* note 6.

242. See James D. Reschovsky & Andrea B. Staiti, *Access and Quality: Does Rural America Lag Behind?*, 24 HEALTH AFFS. 1128, 1130 (2005).

243. The federal definition of rural is any area not within an urban area. *Urban and Rural Classification*, U.S. CENSUS BUREAU, <http://www.census.gov/geo/reference/urban-rural.html> (updated Mar. 7, 2013). The North Carolina Rural Economic Development Center indicates that rural is defined as having a population density of less than two hundred fifty people per square mile, or where at least sixty-six percent of the county land falls below two hundred fifty people per square mile. N.C. RURAL ECON. DEV. CTR., NORTH CAROLINA RURAL PROFILE: ECONOMIC AND SOCIAL TRENDS AFFECTING RURAL NORTH CAROLINA 4 (Feb. 2013), *available at* [http://www.ncruralcenter.org/index.php?option=com\\_content&view=article&id=72&Itemid=123](http://www.ncruralcenter.org/index.php?option=com_content&view=article&id=72&Itemid=123).

option is for North Carolina to define “rural” using the federal guidelines for determining health professional shortage areas. This approach would show the areas of North Carolina that truly lack access to care. A limitation to this approach is that the federal guidelines could change, which would make reimbursement policies complicated.<sup>244</sup> Regardless of how North Carolina chooses to define rural, the rural-only reimbursement statute does nothing to help the statewide expansion of telemedicine because it excludes areas in which there are an adequate number of providers. Therefore, if North Carolina wishes to be at the forefront of the telemedicine movement, the General Assembly should adopt a no-limitations insurance parity law. This would impact all patients with health insurance and signals the general acceptance of telemedicine as an appropriate means to provide care.

#### CONCLUSION

North Carolina’s Telepsychiatry Program is a worthy effort to connect patients to mental health professionals. Many patients will benefit from the program, and the program should allow patients who present acute mental health or substance abuse crisis in an emergency department to “receive timely specialized psychiatric treatment.”<sup>245</sup> However, in order to protect its citizens and become a national leader in the telemedicine movement, North Carolina must update its informed consent, licensure, and reimbursement statutes and regulations. None of these three areas of regulation is currently suitable for telepsychiatry or for telemedicine.

The lack of required informed consent could deprive patients of learning of the risks of telemedicine, such as the possibility that the videoconferencing “systems are vulnerable to failure and unauthorized access . . . .”<sup>246</sup> North Carolina should update its informed consent law by mandating the information that should be included in the informed consent. This would ensure that all patients receive the same information while avoiding burdening the physician.

North Carolina’s licensure laws also do not specifically mention telemedicine, which is a significant barrier to the expansion of

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244. Health professional shortage areas may change as the population or number of physicians grows. See *Mental Health HPSA Designation Overview*, HEALTH RESOURCES & SERVS. ADMIN., <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsaoverview.html> (last visited Nov. 3, 2014). However, a way to combat this problem is to tie the federal guidelines to a specific date.

245. N.C. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 7.

246. Fleisher & Wagner, *supra* note 119, § 1.04(3), at 1-63.

telemedicine in North Carolina. In order to become a national leader in telemedicine, North Carolina needs to open its borders to out-of-state telemedicine practitioners by issuing telemedicine licenses to qualified practitioners. North Carolina should ensure quality by requiring applicants to be board-certified in their specialty.

Finally, North Carolina does not mandate reimbursement from third-party insurers for telemedicine. This is a significant barrier to the patient because insurance coverage often determines whether or not the patient can afford telemedicine. To ensure that all North Carolinians are able to have better access to care and access to better care, North Carolina must mandate insurers to cover all services appropriately provided through telemedicine. If North Carolina updates its informed consent, licensure, and reimbursement statutes, it will surely protect the citizen-patient and become a national leader in telemedicine.

JENNIFER M. LITTLE\*\*

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TABLE I: FIFTY STATES: TELEMEDICINE LAWS FOR INFORMED CONSENT<sup>247</sup>

State	Informed Consent		
	General	Specified Information	Specified Provider
AL	–	Yes <sup>248</sup>	–
AK	–	–	–
AZ	Yes <sup>249</sup>	–	–
AR	–	–	–
CA	Yes <sup>250</sup>	–	–
CO	–	Yes <sup>251</sup>	–
CT	–	–	–
DE	–	–	–
FL	–	–	–
GA	–	–	–
HI	–	–	–
ID	–	–	–

247. Tables 1, 2, and 3 are updated as of January 26, 2015.

248. ALA. ADMIN. CODE r. 540-X-15.08 (2014).

249. ARIZ. REV. STAT. ANN. § 36-3602(A) (2009).

250. A.B. 809, 2013, Reg. Sess. (Cal. 2014).

251. COLO. REV. STAT. § 25.5-5-320(4) (2012).

IL	–	–	–
IN	–	–	–
IA	–	–	–
KS	–	–	–
KY	Yes <sup>252</sup>	–	–
LA	–	Yes <sup>253</sup>	–
ME	–	–	–
MD	Yes <sup>254</sup>	–	–
MA	–	–	–
MI	–	–	–
MN	–	–	–
MS	–	Yes <sup>255</sup>	–
MO	Yes <sup>256</sup>	–	–
MT	–	–	–
NE	–	Yes <sup>257</sup>	–

252. KY. REV. STAT. ANN. § 311.5975(1)(a) (West 2013).

253. LA. ADMIN. CODE tit. 46, § 7511 (2011).

254. MD. CODE REGS. 10.32.05.06(d)(1) (2013).

255. 30-2635 MISS. CODE. R. § 5.3 (LexisNexis 2014).

256. MO. REV. STAT. § 208.670.2 (2013).

257. NEB. REV. STAT. § 71-8505(1) (2009).

NV	–	–	Yes <sup>258</sup>
NH	–	–	–
NJ	–	–	–
NM	–	–	–
NY	–	–	–
NC	–	–	–
ND	–	–	–
OH	–	–	Yes <sup>259</sup>
OK	–	Yes <sup>260</sup>	–
OR	–	–	–
PA	–	–	–
RI	–	–	–
SC	–	–	–
SD	–	–	–
TN	–	–	–
TX	Yes <sup>261</sup>	–	–

258. NEV. ADMIN. CODE § 633.165(1) (2013).

259. OHIO ADMIN. CODE 4753-2-01(A)(3) (2014).

260. OKLA. STAT. ANN. tit. 36, § 6804 (West 2009).

261. TEX. OCC. CODE ANN. § 111.002 (West 2012).

UT	-	-	-
VT	-	-	Yes <sup>262</sup>
VA	-	-	-
WA	-	-	-
WV	-	-	-
WI	-	-	-
WY	-	-	Yes <sup>263</sup>

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262. VT. STAT. ANN. tit. 18, § 9361(b) (2012).

263. 6-62 WYO. CODE R. § 1(d) (LexisNexis 2012).

TABLE II: FIFTY STATES: TELEMEDICINE LAWS FOR LICENSURE

State	Licensure			
	Telemedicine License	Any Physician	Geographic Restriction	Physician Exemption
AL	–	Yes <sup>264</sup>	–	–
AK	–	–	–	–
AZ	–	–	–	–
AR	–	–	–	–
CA	–	–	–	–
CO	–	–	–	–
CT	–	Yes <sup>265</sup>	–	–
DE	–	–	–	–
FL	–	–	–	–
GA	–	–	–	–
HI	–	–	–	–
ID	–	–	–	–
IL	–	–	–	–
IN	–	–	–	–

264. ALA. CODE § 34-24-502 (LexisNexis 2011).

265. CONN. GEN. STAT. ANN. § 20-12(a) (West 2012).

IA	–	–	–	–
KS	–	–	–	–
KY	–	–	–	–
LA	Yes <sup>266</sup>	–	–	–
ME	–	–	–	–
MD	–	–	–	Yes <sup>267</sup>
MA	–	–	–	–
MI	–	–	–	–
MN	–	Yes <sup>268</sup>	–	–
MS	–	Yes <sup>269</sup>	–	–
MO	–	–	–	–
MT	Yes <sup>270</sup>	–	–	–
NE		–	–	–
NV	Yes <sup>271</sup>	–	–	–
NH	–	–	–	–
NJ	–	–	–	–

266. LA. REV. STAT. ANN. § 37:1276.1(A) (2013).

267. MD. CODE ANN., HEALTH OCC. § 14-302(4) (LexisNexis 2012).

268. MINN. STAT. ANN. § 147.032(1)(a) (West 2013).

269. MISS. CODE ANN. § 73-25-34(2) (West 2012).

270. MONT. CODE ANN. § 37-3-343 (2011).

271. S.B. 327, 2013 Leg., 77th Sess. (Nev. 2013).

NM	Yes <sup>272</sup>	–	–	–
NY	–	–	–	–
NC	–	–	–	–
ND	–	–	–	–
OH	Yes <sup>273</sup>	–	–	–
OK	–	–	–	–
OR	–	Yes <sup>274</sup>	–	–
PA	–	–	Yes <sup>275</sup>	–
RI	–	–	–	–
SC	–	–	–	–
SD	–	–	–	–
TN	Yes <sup>276</sup>	–	–	–
TX	Yes <sup>277</sup>	–	–	–
UT	–	–	–	–
VT	–	–	–	–
VA	–	–	–	–

272. N.M. STAT. ANN. § 61-6-11.1(A) (West 2012).

273. OHIO REV. CODE ANN. § 4731.296(C) (LexisNexis 2012).

274. OR. REV. STAT. § 677.139(1) (2007).

275. 63 PA. CONS. STAT. § 422.34(a) (West 2012).

276. TENN. CODE ANN. § 63-6-209(b) (2012).

277. 22 TEX. ADMIN. CODE § 172.12(a) (2013).

2015]

*NORTH CAROLINA TELEPSYCHIATRY*

907

WA	-	Yes <sup>278</sup>	-	-
WV	-	-	-	-
WI	-	-	-	-
WY	-	-	-	-

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278. WASH. REV. CODE ANN. § 18.71.030(6) (West 2013).

TABLE III: FIFTY STATES: TELEMEDICINE LAWS FOR LICENSURE  
FOR PRIVATE REIMBURSEMENT

State	Private Reimbursement		
	No Limitations	Rural Patients Only	Physician Must Be Present
AL	–	–	–
AK	–	–	–
AZ	–	Yes <sup>279</sup>	–
AR	–	–	–
CA	Yes <sup>280</sup>	–	–
CO	–	Yes <sup>281</sup>	–
CT	–	–	–
DE	–	–	–
FL	–	–	–
GA	Yes <sup>282</sup>	–	–
HI	Yes <sup>283</sup>	–	–
ID	–	–	–

279. S.B. 1353, 51st Leg., 1st Reg. Sess. (Ariz. 2013).

280. CAL. HEALTH & SAFETY CODE § 1374.13(c) (West 2012).

281. COLO. REV. STAT. § 10-16-123(2) (2012).

282. GA. CODE ANN. § 33-24-56.4(d) (2013).

283. HAW. REV. STAT. ANN. § 431:10A-116.3(b) (LexisNexis 2011).

IL	–	–	–
IN	–	–	–
IA	–	–	–
KS	–	–	–
KY	Yes <sup>284</sup>	–	–
LA	–	–	Yes <sup>285</sup>
ME	Yes <sup>286</sup>	–	–
MD	Yes <sup>287</sup>	–	–
MA	–	–	–
MI	Yes <sup>288</sup>	–	–
MN	–	–	–
MS	Yes <sup>289</sup>	–	–
MO	Yes <sup>290</sup>	–	–
MT	Yes <sup>291</sup>	–	–
NE	–	–	–

284. KY. REV. STAT. ANN. § 304.17A-138(1)(a) (LexisNexis 2011).

285. LA. REV. STAT. ANN. § 22:1821(F)(1) (2013).

286. ME. REV. STAT. ANN. tit 24-A, § 4316 (2012).

287. MD. CODE ANN., INS. § 15-139(c) (LexisNexis 2012).

288. MICH. COMP. LAWS § 500.3476(1) (2013).

289. MISS. CODE ANN. § 83-9-351(2) (2014).

290. MO. REV. STAT. § 376.1900.2 (2013).

291. S.B. 270, 63rd Leg., Reg. Sess. (Mont. 2013).

NV	–	–	–
NH	Yes <sup>292</sup>	–	–
NJ	–	–	–
NM	Yes <sup>293</sup>	–	–
NY	–	–	–
NC	–	–	–
ND	–	–	–
OH	–	–	–
OK	Yes <sup>294</sup>	–	–
OR	Yes <sup>295</sup>	–	–
PA	–	–	–
RI	–	–	–
SC	–	–	–
SD	–	–	–
TN	–	–	–
TX	Yes <sup>296</sup>	–	–

292. N.H. REV. STAT. ANN. § 415-J:3(II) (LexisNexis 2012).

293. S.B. 69, 51st Leg., 1st Sess. (N.M. 2013).

294. OKLA. STAT. ANN. tit. 36, § 6803(A) (West 2009).

295. OR. REV. STAT. § 743A.058(c)(2) (2011).

296. TEX. INS. CODE ANN. art. 1455.004(a) (West 2009).

UT	-	-	-
VT	Yes <sup>297</sup>	-	-
VA	Yes <sup>298</sup>	-	-
WA	-	-	-
WV	-	-	-
WI	-	-	-
WY	-	-	-

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297. VT. STAT. ANN. tit. 8, § 4100k(a) (2012).

298. VA. CODE ANN. § 38.2-3418.16(C) (2014).